DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 2003 — 16

2. STATE: Florida

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.54 (a)(2)

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ (2,988)
b. FFY 2004 $ (11,[illegible])

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.18-A, page 1
Attachment 4.18-C, page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.18-A, page 1
Attachment 4.18-C. page 1

10. SUBJECT OF AMENDMENT:
Coinsurance on Non-Emergent Hospital ER Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
comments will be forwarded when received

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Bob Sharpe

13. TYPED NAME:
Mr. Bob Sharpe

14. TITLE:
Deputy Secretary for Medicaid

15. DATE SUBMITTED:

16. RETURN TO:
Mr. Bob Sharpe
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, FL 32308
ATTN: Kay Newman

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 2, 2003

18. DATE APPROVED:
October 17, 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Susan Cuerdon

21. TYPED NAME:
Susan Cuerdon

22. TITLE:
Acting Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State FLORIDA

a. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge			Amount and Basis for Determinations
	Deduct.	Coins.	Copay	
Hospital Services: Non-emergency services in the hospital emergency room.		X		Effective July 1, 2003, there is a five (5) percent coinsurance charge to recipients 21 years of age or older on Medicaid payments greater than $0.00 through the first $300 per date of service for non-emergency services rendered in a hospital emergency room. There is 0% coinsurance on Medicaid payments in excess of $300. Providers are responsible for collecting the cost sharing charges from recipients not otherwise exempt. Providers cannot deny services to recipients who are unable to meet their cost sharing obligation. Authority for the maximum charge is 42 CFR 447.54(a)(2). All exemptions to cost sharing noted in 42 CFR 447.53(b)(1)-(5) apply.

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